island
Home Care Agency, Inc
631-289-6223 Fax 631-289-7473

PATIENT FINANCIAL LIABILITY AND CONSENT FORM

**************************IMPORTANT PLEASE READ!!**************************

Patient Name:_____ ID # _____

Effective Date: _____ Visits authorized_____

Your primary insurance company is:_____,Your secondary insurance company is: _____. Your deductible is: _____, Your Out of Pocket expense is_____, You will be responsible for the entire charge per visit until your deductible has been met, then _____% until your out of pocket expense has been met **For the duration of your care with IHC**, your health insurance benefit requires you to pay the following out of pocket expenses: **(not applicable to CareCentrix)**

$_____ ***co-pay per visit / $_____*co-insurance per visit**

IF YOU ARE A CARECENTRIX PATIENT:
Please contact the CareCentrix Patient Service Team directly at 800-808-1902, and select option 2. This team oversees CareCentrix patient collections in addition to explaining member copay and deductible amounts, and they can also answer any questions about the member's patient collection statement.

(Pertaining to all insurances):
As per your annual benefit, you can receive _____ visits per calendar year.

These fees are per visit for each professional service that walks into your home.

I authorize Island Home Care Agency to bill my credit card for each service rendered at the time of each visit.

_____
(Patient/Responsible Other Signature)

/OR/ I have paid by Check ☐ _____. Rec'd by_____

(Patient/ Responsible Other Signature) (Nurse/Therapist Signature)

Please Note: We are a licensed agency, and as such, cannot bill co-pays/co-insurance to Medicaid or Medicare. If, for any reason, you are not completely satisfied with the services you are receiving from us, please notify Genina, The Director of Patient Care Services immediately – 631-289-6223 ext 12.Thank you.

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I understand that I am responsible for any health insurance deductibles, co-pays and co-insurance charges if it is part of my contract. I understand that the total visits per calendar year are part of my insurance contract and are *not* specifically benefits still available as of this date. If my liability for payment changes, I will notify Island Home Care Agency, or Island Home Care Agency will notify me as soon as possible but no later than 30 calendar days that either of us become aware of the change. The above patient responsibility could change upon subsequent insurance verification. I certify that the information given by me in applying for payment is correct; I authorize the release of any information needed to act on this request. I request payment of authorized benefits be made in my behalf.

_____ _____
Date Signature of Patient

_____ _____
Signature of Responsible Other Reason for Other Signature

I have presented and explained the above Patient Liability/Consent for Payment to the Patient/ Representative:

_____ _____
Date Island Home Care Agency Staff Member

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